# Appendix #10

## Department of Social Services Inspector Survey Results

**DRAFT**
**Inspector Survey Results**

As part of the study, to obtain answers to the following questions relating to Virginia's ALFs, their oversight, and resident characteristics, it was deemed that the inspectors of the ALFs could best provide the answers. This survey was sent to all the regional supervisors to be distributed to individual inspectors. Inspectors were surveyed rather than the facilities, themselves, for four reasons: (1) concern over the perennial problem of low survey response rates in any survey; (2) potential respondent bias; (3) with over 600 facilities, the cost of sending and receiving surveys; and (4) the fact that DSS inspectors have the unique perspective of having observed what occurs in many facilities rather than one. The last point was viewed as providing the study with cross-sectional views of what is occurring in Virginia's ALFs as well as what may be going on in each facility.

1. **Is there someone in a supervisory capacity to oversee the care and safety of the residents 24-hours a day? Is there a need for such supervision**?

2. **What are the characteristics of the residents at the facilities:**
    a. **Do most need minimal assistance with activities of daily living?**
    b. **How typical is it that a greater level of assistance is required, including that for individuals with behavioral or substance abuse problems who may pose a danger to the other residents? What steps are taken to ensure the safety of others as well as themselves?**

3. **What is the typical process used to assess the resident to determine whether the facility can adequately meet the resident's needs. Is this "fit" re-evaluated periodically?**

4. **Are there data available on medication errors and who makes them? If so, can you establish the backgrounds of those individuals who have made the errors? RN? LPN? Someone who has completed a training program to administer medications pursuant to §54.1-3408 (J)?**

## 1. Is there someone in a supervisory capacity to oversee the care and safety of the residents 24-hours a day?

Inspector A - Yes

Inspector B - Some ALFs have 24-hour licensed nurses 7 days/wk
The majority have unlicensed "lead case managers" or "shift supervisors"

Inspector C - Unclear as to the type of supervision referenced in the question. Response notes that if in reference to **oversight of resident care and safety**, then alert and awake care managers are available 24/7 (except in buldings with <=19 residents and each resident has agreed that they do not need to have a staff member awake throughout the night. If **administrative oversight of the program of care**, then some larger programs do have administrative oversight personnel during all shifts. However, the majority do not nor do the small homes (<5 residents).

Inspector D - No, only during day working hours in the larger facilities. In the smaller facilities, a designated administrator is there in the day but not night.

Inspector E - Usually not in the evening/night shifts in the larger facilities. In smaller facilities, the supervisor may oversee several small homes or have designated administrators during the day but not evening/night.

Inspector F - Regulation requires 24/7 supervisory presence. However, depending upon the nature of cognitive impairment and number of residents. Only about 5% of the ALFs in this inspector's caseload have an administrator or health care practitioner (i.e., nurse) overnight. About 15-20% have a nurse or designated administrator on duty on weekend days. Most of the larger facilities staff nights and much of the weekend with at least one direct care staff person (some CNA's but mostly individuals who have received 40 hour direct care staff training designated as "lead" care manager. They are usually medication aide trained and/or CPR/First Aid certified.
**NOTE: This inspector notes having investigated numerous complaints where staff are hired, trained in direct care, and placed in the lead position in a relatively short period of time -- often responsible for a large facility and several lesser trained staff, all with very little actual experience in that particular facility.**

Inspector G - Administrator/DON are on duty during normal business hours. Several facilities designate a staff member to be in-charge during evening/night hours. The majority of ALFs have direct care staff awake and on duty at night. A management staff person is on call to assist staff in emergency situations.

Inspector H - Yes.

Inspector I - All facilities have a person who is supposed to act in the "charge person" role.

Inspector J - Most ALFs have a person who operates in a supervisory capacity. It may be a nurse, management team member, or a medication aide or caregiver who is designated to be in charge

Inspector K- Most ALFs have someone of a designated supervisory status on duty 24 hours/day.

## 1. Is there someone in a supervisory capacity to oversee the care and safety of the residents 24-hours a day? (continued)

Inspector L – In the Auxiliary Grant ALFs, no one is designated as a supervisor for the entire day. During the day, the ALF administrator is in the supervisory role. However, after that the "in charge" status is transferred usually to a medication technician. In facilities that are private pay, the supervisor is an RN or LPN.

Inspector M – In ALFs where only one staff member is on duty (especially over night), the staff person calls the administrator or supervisor who may be on duty during other hours for questions or assistance.

In ALFs with more than one staff member on duty, a similar procedure is followed; however, others ALFs have staff who carry the title "supervisor." This supervisor may be a more experienced staff person but with more limited authority than and report to the the ALF administrator. This protocol may or may not be established on all shifts.

In larger facilities with more staff, departments may be defined by function and have their own heads who serve as supervisors reportable to the Adminstrator. A supervisor may not be on premises at all times.

Inspector N – Varies widely – some ALFs have a nurse on duty at all times, some schedule a member of the management team. Others (most likely the majority) have a medication aide or caregiver designated to be in charge. **The Inspector reports that some have a few caregivers present with no one specifically in charge, especially during the evening/night shifts. Although not present, the supervisory staff may be on-call.**

Inspectors O1 and O2 – Yes, except in the smaller "ma/pa" ALFs. In some of these, staff will normally call the administrator/director or a nurse.

Inspector P – Not in all facilties. Many of the smaller facilities have one staff at night or may have two or three **with no one really supervising.** Most of the ALF administrators are available by phone at night if a problem arises.

Inspector Q – ALF administrator is usually on site during the day. After this, it is usually direct care staff providing supervision to the residents. **Some ALFs designate a direct care staff persons as a supervisor and others do not.**

Inspector R – Supervisory/administrative staff is present during the day. In smaller facilities, there is usually one or two staff present on the evening/night shifts. **There is no designated supervisor.** The ALF administrator/supervisor is contacted by telephone in emergencies. **Inspector notes that employees are often in the position of making judgment calls regarding what course of action to take in unforeseen situations.**

Inspector S – In most ALFs there is an "in-charge" person 24/7. However, the supervisory staff are present at the facility during the day only. **Inspector notes that individuals left "in-charge" do not always step up to the plate when it comes to making critical decisions after hours. Inspector further reports that some of these individuals do not feel that they have the knowledge, skills, and abilities, nor the authority to be making supervisory decisions.** In a small number of facilities, there is a supervisor (usually RN/LPN) on duty 24/7.

## 1. Is there someone in a supervisory capacity to oversee the care and safety of the residents 24-hours a day? (continued)

Inspector T – Yes, as required by Standard 20. This person could be an LPN, RN, direct care staff, administrator or assistant.

Inspector U – The larger corporate ALFs usually have a supervisory 24 hours. Smaller partnership and individually owned ALFs most often have one or more direct care staff on duty. A few of the smaller (<=30) incorporated facilities sometimes staff only direct care staff during the evenings and night hours.

Inspector V- Supervisory/administrative staff typically work during the day. **Inspector reports that at other times (nights and weekends) the individuals responsible to oversee the care and safety of residents are direct care staff, receptionists, cooks, and housekeeping personnel who do not have the training or authority to make decisions regarding the care of the residents. The inspector reports that over the past year he has noticed that these individuals are now being left in a supervisory capacity at a facility during the day. This occurs in private pay as well as public pay facilities.**

Inspector W- There is at least a direct care staff person on duty – who may not be a supervisor.

## Is there a need for such supervision?

Inspector A - Yes

Inspector B - The answer depends on the acuity levels of residents and their medical needs.

Inspector C - Small homes do not need administrative oversight on every shift because these homes are locally run, with administrators/operators close by overseeing several small homes. They are readily available by telephone. For those that do not have close by availability, there should be 24/7. An administrator is usually assigned for the weekends but not nights. A nursing home administrator may not be needed for all shifts but an R.N. or L.P.N. should be available.

Inspector D - Yes

Inspector E - Yes

Inspector F - Yes a need for supervision but not necessary for administrator 24/7. Inspector indicates a difference for small vs. large facilities. For the small (6-8 resident homes, a trained direct care staff person is usually sufficient relative to the types of impairment seen I these homes. The larger facilities tend to have a greater number of residents with significant impairment. In these situations, there is a need for someone of an administrative nature on site 24/7. Questions what would constitute a larger facility.

Inspector G - Inspector opines that it would be beneficial to mandate that all ALFs designate a staff member to be in charge when supervisory/management staff are not present. Also notes that it would be Helpful if the name of the "supervisor/manager-on-duty" be posted to enable residents, family, visitors, etc. to have a point of contact for questions and concerns. **NOTE: This inspector has heard from both residents and family members that "NO ONE SEEMS TO BE IN CHARGE."**

Inspector G also contends that it would be beneficial to the residents' overall level of care if there was a licensed nurse on staff and/or call at all times. The Inspector notes that direct care staff and medication aids have minimal training. The inspector reports that this level of training is sufficient for residents with need for minimal assistance. **However, this inspector also reports that there are some ALFs that "retain residents that require assistance with all ADLs, have multiple diagnoses and specific care issues which [is] often beyond the scope of what a medication [aid] or direct care staff should be doing."** The Inspector notes the opinion that ALFs have significantly moved from being a "Social Model" to being more of a "Medical Model."

Inspector H - Yes, refer to Standard 20 A in the regulations.

Inspector I - Notes a concern when the facility does not have an assigned staff person and something goes wrong (i.e., resident injury or elopement). Then none of the staff will assume the "charge" role.

Inspector J – Supervision is needed for accountability and better assurance of quality of care – better efficiency and effectiveness when someone is "in charge."

## Is there a need for such supervision? (continued)

Inspector K – Expresses concern over the training, supervisory experience and education of the person in the position. Points to the need for supervisor to be on duty 24/7.

Inspector L – Opines that there is a need for a supervisor 24 hours because many ALFs have only direct care staff. **NOTE: This inspector indicates that when there is a resident issue that direct care staff are unsure how to handle, they simply do not know what to do. Examples cited are: medication errors, receiving orders from physicians, injuries, and falls.**

Inspector M – 24 hour oversight and supervision is necessary, regardless of title. The inspector posits that the need for someone to take responsibility for the well-being of the residents is essential. **NOTE: The inspector indicates that there is some tendency among some direct care staff to not take responsibility for what they perceive as not in their job description.**

Inspector N – Inspector indicates from personal observation that facilities are more Effective when someone present has been designated to have a supervisory capacity for each shift. If a management team member or nurse cannot be present, having either of these on-call is helpful.

InspectorsO1 & O2 – no comment on this.

Inspector P – with the administrator available by telephone by night, it may not be necessary to have them on site 24/7.

Inspector Q – Inspector states that there is a need for 24 hour supervision **so that direct care staff can be monitored performing their responsibilities to ensure that adequate care is being provided to the residents after hours.**

Inspector R – Inspector holds that 24/7 supervision is needed by someone in a position of authority **and can be held accountable for the care and safety of the residents.**

Inspector S – Inspector contends that there is a definite need to have on-premise supervision 24/7.

Inspector T – Yes, because of the varying levels of care.

Inspector U - Yes, Inspector suggests that 24 supervisory staff would be an asset in facilities with 30+ residents. **Inspector notes a greater spectrum of complex needs in the larger facilities. Inspector opines that it reminds her of nursing facilities years ago that did not provide skilled care. Inspector posits that there has been a shift in population and setting. Inspector has specific concerns that the direct care staff are not equipped to make some of the difficult decisions when a supervisor is not on duty.** The inspector reports that records reflect that persons had to be called and awakened to get instructions on how to handle a given situation.

Inspector V- Yes, especially at night and weekends when staffing levels are reduced making the need for supervision more critical.

Inspector W – Sometimes, it depends on the number and needs of those in care and the skill level of the staff on duty.

## 2. What are the characteristics of the residents at the facilities:

### a. Do most need minimal assistance with activities of daily living?

Inspector A – Most need moderate assistance with ADLs.

Inspector B - Majority of residents are dependent with at least one ADL or most IADLs.

Inspector C - Mixed and depends on the individual facility. Some require assistance with all ADLs, others need only minimal assistance. Others are fully independent.

Inspector D – Yes, several require help with all ADLs & IADL's,not just minimal assistance.

Inspector E - Depending upon the ALF, some have residents that require assistance with all of their ADLs.

Inspector F – No, most need assistance with 2-3 ADLs plus medication administration

Inspector G – The majority of ALFs require "human" help (i.e., supervision or physical assistance with 2-3 ADLs. There are some that require assistance with all ADL's **Note: the inspector reports that in onefacility, the majority of residents Fall into the "Intensive" assisted living category.**

Inspector H- Depends on the type of license and level of care indicated on the UAI and DMAS 96. Residents in the residential care level should only require minimal assistance. Those that require additional assistance should reside in the assisted living care level facility.

Inspector I – Yes.

Inspector J – Most require assistance with ADLs. Some require minimal assistance. However the majority need more than minimal assistance. The inspector reports that **some ALFs have residents who would qualify for nursing home level care, others residential level.**

Inspector K- 51% assisted living, 30% mental health/mental retardation assisted Living, and 19% residential. **Most of these need little more than minimal assistance. Most in the assisted living situations require more than minimal assistance.**

Inspector L – Most in the private pay ALF are high functioning until they reach dementia assessment or meet nursing home requirements. It is difficult to place Auxiliary Grant residents with mental or behavioral health issues.

Inspector M – Great deal of variability depending upon the population that the ALF has chosen – some only accept residents with minimal assistance needs. The majority of residents that the inspector works with requires minimal assistance with at least one ADL, some are mixed, and some maximum assistance. A greater level of assistance is common, most typically assistance with bathing and dressing, toileting and incontinence is very common and some assistance with transferring is often assessed with toileting needs and incontinence.

Inspector N- This varies by facility. Some have independent units/apartment/cottages that may be licensed by DOLP with residents who do not need ADL assistance. Most residents require help with ADLs. The inspector opines that **most residents require more assistance than residential care, and in many facilities, a significant number would qualify for nursing home care.**

## 2. What are the characteristics of the residents at the facilities:

### a. Do most need minimal assistance with activities of daily living?

Inspector O1 & O2- These inspectors report that they view that many of the ALFs are **"mini-nursing homes"** and that many of the residents need more than minimal assistance.

Inspector P – Varies. More assistance is needed for residents with behavioral problems.

Inspector Q – Most residents need moderate assistance, although this can fluctuate

Inspector R - 80% of residents are in need of assisted living care (vs. residential care) The trend appears to be rising for more "intensive" care. **Inspector notes that there now are greater problems with cognitive impairments, mental health/behavioral problems, physical disabilities, serious medical problems such as cancer, dialysis, insulin dependency, breathing problems, mobility problems than in the past and ALFs now have residents who are bedridden.**

Inspector S – There is a wide spectrum of characteristics – young, old, and middle-aged mentally ill and/or retarded to frail elderly.

Inspector T – Most need residential care, minimal assistances with ADL (largely instrumental and medicine administration). Residential only are smaller facilities. Mixed care levels are common. Several facilities have residents with Alzheimer's and serious cognitive impairment.

Inspector U – Mixed population noted. **Note: Inspector cites that he is beginning to see more hospice cases and persons who are totally dependent in all ADLs. He also notes that some residents who qualify for nursing home care are paying privately to stay at an ALF**

Inspector V – Assistance with medication administration, housekeeping, meal preparation, hygiene, grooming, laundry, mobility, transportation, securing and making appointments for needed care, completing paperwork for benefits, and managing personal funds are the most common factors.

Inspector W – Moderate assistance.

**b. How typical is it that a greater level of assistance is required, including that for individuals with behavioral or substance abuse problems who may pose a danger to the other residents?**

Inspector A – Very typical

Inspector B – The secured units in the ALFs have residents that require a higher level of care. Both behavioral and substance abuse problems are present.

Inspector C – Mixed – some have a low level of required assistance and others must work on behavioral issues on a full time basis.

Inspector D – The inspector indicates that it varies with each facility but is very typical as the residents age, including behavioral or substance abuse problems.

Inspector E – ALF-specific but some deal with behavioral problems on a daily basis.

Inspector F - This inspector has no facilities with residents with substance abuse problems that would pose a danger to others. Those with behavioral problems related to dementia – especially those in the larger facilities with special care units require a greater level of assistance.

Inspector G – Typical. **NOTE: Inspector speculates that this is due to facilities wanting to retain residents even when health declines.** No behavioral or substance abuse issues, except those with cognitive deficits.

Inspector H – **NOTE: Inspector reports that some placements may not be appropriate for an ALF as some individuals should be placed in a mental health setting. Inspector also reports that the ALF may not always receive adequate support services from mental health and community service agencies. Consequently when behavioral problems or substance abuse become overt and noted by family members, case managers and the psychiatrist, generally the resident becomes hospitalized. The inspector opines that there are times when the care is beyond the scope that the ALF can provide to ensure safety. The resident is then generally transferred to another facility on a trial basis once released from the hospital.** Refers to Standards 45, 660, 670, 680, 170, and 160.

Inspector I – This inspector notes that there are seven secured units in his caseload and two additional facilities that cater to a high acuity care needs ("Intensive" ALF by the old regulation definitions). Only one facility admits residents with primarily a psychiatric definition.

Inspector J - **The inspector contends that residents with behavioral or substance abuse problems who may pose a risk to others do not often require physical assistance.**

Inspector K – Typical.

Inspector L – Typical to need more than minimal assistance or need maximum supervision to make sure ADL's are done with mental health residents.

## b. How typical is it that a greater level of assistance is required, including that for individuals with behavioral or substance abuse problems who may pose a danger to the other residents? (continued)

Inspector M – Active substance abuse problems are rare for this inspector. Residents obtaining beer or wine when spending money is received poses a problem, especially in maintaining medication administration. Alcohol use has prompted verbal arguments and some physical episodes. Illegal use of drugs has been limited to a few residents in a few facilities. Inspector notes that a larger problem is misuse of pain medication facilitated by going to several doctors for prescriptions.

Inspector N – **Inspector posits that many residents with behavioral or substance abuse problems who pose a potential threat to other residents do not have significant physical limitations. However, the threat that they pose often decreases as the residents become more physically disabled.**

Inspector O1 & O2 – Typical.

Inspector P – Typical. Inspector reports that facilities in the area will accept individuals **severe behavioral problems** because of **vacancies.**

Inspector Q – This inspector holds that those with behavioral and/or substance abuse problems cannot be admitted to an ALF.

Inspector R – Typical.

Inspector S – Not noted.

Inspector T – Greater level typically required. At least 2 ADLs. **Some small, private homes have the majority of residents with intensive levels of are – borderline nursing home – requiring 4 or more ADLs (bathing, dressing, feeding, toileting, also IADLs meal preparation, laundry, medication administration, housekeeping, financial management – total care. Home health agencies are sometimes involved and private duty nurses.**

Inspector U – Not indicated.

Inspector V - Residents with behavioral or substance abuse problems are problematic. **The inspector views that staff is not skilled or trained to work with them and these residents are typically younger and pose a risk to the frail/elderly population in terms of physical/mental abuse, exploitation, etc.**

Inspector W – Very.

## What steps are taken to ensure the safety of others as well as themselves?

Inspector A – Staff supervision and monitoring, physician and case managers interventions when necessary.

Inspector B – Increased staffing levels and specific training on these behaviors as well as physical plant requirements such as in 700 B & C.

Inspector C – The care program with therapies and staff supervision are theoretically designed to ensure safety. Some ALFs have better operational approaches. **Inspector notes: Any facility can have a resident take a turn for the worse.**

Inspector D – Inspector states that some steps are provided in the DSS training areas of the standards. **The UAI helps to identify behavioral problems, disorientation, and whether or not the resident needs a psychiatric or psychological evaluation.** Another step is staff reporting concerns in daily logs and staff communication logs. Other steps mentioned are physician reports, medication therapy reports and mental health progress reports.

Inspector E – Medication therapy and staff supervision. For the larger ALFs, **inspector reports that some residents might "slip through the cracks." Inspector further indicates that he has not seen a good system of tracking these kinds of behaviors in any of the facilities.**

Inspector F - Inspector reports that only a small portion of ALFs that are large do NOT have special care units.

Inspector G – Inspector reports that **with the minimal behavioral issues that he has been made aware of, the facilities appear to ensure the safety of the residents and others.** This is generally accomplished by involving mental health professionals to evaluate and treat, as well as staff education.

Inspector H – **Inspector reports that during the admissions process residents are assessed by several methods in addition to the UAI.** Interviews are held with the prospective resident and family members or other responsible parties. Physicals and psychiatric assessments are done. Some facilties have additional internal assessments. **Individualized service plans are initiated based on identified needs. The assessments are done annually and when there has been a significant change in the resident's condition lasting 30 days or longer.** At that point, individualized service plans are reviewed and updated (Standards 150, 170, 660, 640, and 690).

Inspector I – ALFs are to update UAI's at least every 12 months.

Inspector J - **These residents are often monitored on at least a six-month basis by mental health professionals with reports kept in the resident's records. Staff are trained on mental health issues and residents followed with a medication management plan. If the resident becomes unmanageable, he will typically be discharged to a facility that can better handle his needs.**

Inspector K – Adequate staff in numbers at all times and ensure that staff are trained to assist the population and make sure that changes in levels of care needed are identified by staff and reported to the administrator.

## What steps are taken to ensure the safety of others as well as themselves? (continued)

Inspector L – They should be followed by a mental health.

Inspector M – Depending on the circumstances of the problem encountered, family members and case managers have been called for minor incidences. The police or mental health crisis staff have been called to remove residents if behavior gets out of control.

Inspector N – **The inspector holds that facilities often attempt to keep the residents with behavioral or substance abuse issues separate from the general population, but confrontations still occur. Case planning and intervention from mental health professionals are commonly used to reduce the risks and staff oversight and medication management also used. If the endangering behaviors become unmanageable, discharge is appropriate. Sometimes this is accomplished with police and/or mental health intervention and may be an emergency discharge. Facilities experience pressure from family members who do not want the potentially dangerous residents discharged, and often alternate placements are difficult to locate. The inspector offers that having separate facilities licensed under mental health agencies and administered by trained mental health workers would help to alleviate this type of potentially dangerous situation.**

Inspectors O1 & O2 – These inspectors report that the following measures being taken:

- Sitters for residents
- Discharge of residents
- Closer documentation of monitoring the resident
- Increased training of staff
- No or decreased complaints from staff that they cannot handle the population
- Observation of staff taking care of residents
- Reviewing "Health Care Oversight" and other documentation for additional information, if it is completed
- Hospice, if applicable
- Home health nursing, if applicable

Inspector P- **Inspector expressed concern over facility not being able to adequately meet the need of these residents, citing minimal training and proper planning. Concern about abuse and neglect noted.**

Inspector Q – It doesn't happen in this area.

Inspector R – Cognitively impaired residents are placed in secure units or the facility is required to have a security monitoring system. The inspector notes, however, that this does not preclude resident-to-resident abuse or injury from individuals who are prone to episodic behavioral outbursts.

Inspector S – The inspector observes that residents with behavioral or substance abuse problems do not necessarily pose a danger to themselves or others. Notes as steps, sign-in/out sheets, staff communication logs, and "green warrants."

## What steps are taken to ensure the safety of others as well as themselves? (continued)

Inspector T- Inspector notes that those with behavioral or substance abuse problems are active with mental health. **Note: Inspector reports that community service boards, case managers, and crisis intervention may not be sufficiently supportive. The facility may be left with relying on physicians, emergency room or facility staff to handle situations and to follow up on the plan of care.** Some residents have a private psychiatrist at the facility.

Inspector U - **Inspector notes that he is seeing an emphasis being placed on staffing based on residents'needs.** He notes that large facilities often have an LPN or RN on staff and that this is not the case for the smaller facilities

Inspector V – **Inspector considers facilities inadequately prepared to deal with this population. The inspector further opines that community service boards and behavioral health authorities do not provide sufficient support to maintain these individuals safely. Some facilities often need to call the police or many more use facility psychiatrists (who are also often the owners). There is concern regarding allegations of over-medication and inappropriate hospitalization.**

Inspector W – Recommends increased staffing and training about the population served, case management, and doctor/medical interventions.

## 3. What is the typical process used to assess the resident to determine whether the facility can adequately meet the resident's needs. Is this "fit" re-evaluated periodically?

Inspector A – As described in the regulation standards.
Facilty interview and UAI assessment and physical examination completed by the resident's physician. UAI completed annually or when there is a change in the resident's condition.

Inspector B – Same as Inspector A but also notes that most facilities also complete a "mini-mental" evaluation

Inspector C – Same as Inspector A.

Inspector D – Same as Inspector B – notes that change in resident conditions must be for more than 30 days.

Inspector E – Also notes that a family member or resident themselves complete the enrollment forms which may not be accurate.

Inspector F – **The inspector notes that UAI evaluations may be being conducted by someone denoted as the "qualified UAI assessor" but who may also be the marketing individual who has been trained in the UAI, or someone else with alack of any clinical training and/or experience. The inspector further notes that since UAI training can be administered by someone who has received UAI training, but who is not necessarily a UAI trainer, the UAI's are often poorly done and the UAI becomes an unreliable pre-admissions tool, in the opinion of the inspector.**

Inspector G- This inspector notes concern over facilities that strive to retain the resident throughout life (AL philosophy of aging in place) without necessarily having licensed personnel at all times and not only when a specific treatment is ordered. **Inspector also suggests that the private pay UAI needs revision to include more thorough assessment of the resident's needs. There is concern over the fact that ALFs are retaining residents with higher level of care needs. As such, she contends that an annual physical examination is needed.**

Inspector H- As described in the regulations.

Inspector I – As described in the regulations.

Inspector J – As described in the regulations.

Inspector K – Inspector notes concern over inaccurate UAI screening.

Inspector L – Inspector reports that for Auxiliary Grant facilities, the UAI is done by a social-worker or case manager of mental health.

Inspector M – As described in regulations. **Inspector also notes that some facilities do thorough screenings while others may take the approach that it is important to "give the person a try" and thereby accept residents when the fit is not right. Inspector notes concern that ALFs may have an unrealistic assessment of what they can and cannot do to meet the needs of a resident. He sites having to "literally draw the facility a picture to try to help them understand that the resident's needs cannot realistically be met in the the facility based upon his own observations and statements and observations of the staff.**

## 3. What is the typical process used to assess the resident to determine whether the facility can adequately meet the resident's needs. Is this "fit" re-evaluated periodically?

Inspector N – As described in the regulations. Inspector indicates that for private pay residents, the UAI is completed by facility staff at time of admission. **The inspector notes that this often means that the staff only have preliminary information prior to the resident and his belonging arriving at the facility with completed medical form in hand. If there is a question of suitability, then it is difficult or awkward at this stage to turn the resident away. The inspector notes that often the require TB test hasn't been done prior to admission and the staff rarely check "yes" to the question of the need for psychiatric or psychological evaluation and there is no requirement to obtain records on mental retardation or mental health status.**

Inspectors O1 & O2 – As described in regulations.

Inspector P – As described in regulations. Inspector also adds the speculation that the need to fill a bed may override the need for careful evaluation.

Inspector Q- As described in the regulations.

Inspector R – As described in the regulations. **Also the inspector reports that public pay residents' UAIs are completed by physicians, case managers or other public agency assessors. Private pay residents' UAIs are one page and completed by the facility who is admitting the individual. The inspector opines that few are turned away. The inspector conjectures that private pay facilities can accept persons with intensive needs and require the family to pay for the additional support services.**

Inspector S- As described in the regulations.

Inspector T- As described in the regulations.

Inspector U- As described in the regulations. The inspector notes that timely reassessments do not always occur.

Inspector V – As described in the regulations. The inspector adds concern over the fact that several facilities are owned by physicians/psychiatrists who may be making the evaluations. Private UAI's may be biased by census, vacancies,and/or pressures to fill beds. Public pay facilities report difficulty in getting reassessments as residents' needs change (a social worker or other public agency assessor must do this).

Inspector W – As described in the regulations.

**4. Are there data available on medication errors and who makes them? If so, can you establish the backgrounds of those individuals who have made the errors? RN? LPN? Someone who has completed a training program to administer medications pursuant to §54.1-3408 (J)?**

Inspector A – Knows of no database, per se. Inspector has observed errors made by RNs, LPNs, and medication aides.

Inspector B – Same as A, also has observed errors by pharmacies. Noted that errors have been in documentation, transcription, packaging, administration, and simply not following the physician's orders, particularly with regard to increases and decreases in same medication.).

Inspector C –Same as A and has also noted errors made by all three.

Inspector D – Documentation of medication errors are supposed to be on the MARs (Medication Administration Records) and errors should also be documented, when found, on the violation notice. Known medication errors have been associated with medication technicians.

Inspector E – Has seen medication errors by all three. Only known data on violation notice.

Inspector F – Not required of facilities. Could compare MARs with physicians orders.

Inspector G – Not aware of data but has cited facilities for errors by all three.

Inspector H – Notes that facilities have their own pharmacies review.

Inspector I - The inspector explains that the facilities he inspects have tracking programs for medications. Anecdotal observation is that licensed staff appear to find the errors quicker and have a more thorough follow-up.

Inspector J- As in regulations and an explanation of how errors could be checked.

Inspector K – Explanation as to how errors could be checked. Indicates that **Medication errors are common for all staff. Inspector observes that she sees them mainly with medication technicians, some with LPN's and few with RNs. Notes, however, that most facilities just have medication technicians.**

Inspector L - **Inspector notes that medication errors are not often known about by the ALF because there is no one in charge to make sure that physician orders and the MARs match. She notes that in facilities where there is not a nurse, often the orders are difficult to find in the records. Errors are primarily made by medication technicians because most of the facilities she inspects do not have LPNs or RNs. The inspector opines that they do not receive enough training and their certificates are not disciplined if the individual is making errors and is not following what he has been taught in class.**

Inspector M- Notes the most frequent error is that direct care staff and nurses fail to sign off medication as having been given. **The inspector notes problems not only with medication technicians but with supervising nurses.**

**4. Are there data available on medication errors and who makes them? If so, can you establish the backgrounds of those individuals who have made the errors? RN? LPN? Someone who has completed a training program to administer medications pursuant to §54.1-3408 (J)?**

Inspector N – Reports that some facilities maintain a medication error file which may or may not be used by administrative staff in determining who has made errors. Inspector indicates that he has observed errors by all three. He offers that nurses tend to be more aware of the potential consequences of a particular error while medication aides may not.

Inspector O1 & O2 – data could be drawn from the violation notices.

Inspector P – The answer depends on the facility. Some have QA monitoring. These typically report problems to DSS and Adult Protective Services and are aggressive in correcting the problem and preventing future problems. At the other extreme are facilities that wait for the inspector to find the problems.

Inspector Q – relies on self reports completed by those who committee the errors – all three.

Inspector R – sites annual pharmacy reviews. The inspector opines that mostly LPNs and medication technicians administer medications, with RNs serving in a supervisory role.

Inspector S – sites annual pharmacy reviews, also. The inspector notes that MARs are randomly audited throughout the year.

Inspector T – sites pharmacy reviews. Notes that all three are making errors.

Inspector U- sites pharmacy reviews and the fact that training must be verified. Additional training may be recommended by inspectors.

Inspector V – sites pharmacy reviews and that medication technicians administer with LPN and RN oversight.

Inspector W – opines that all staff passing medications have probably made errors.